MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11269

11302 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3yrs 4mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 5706 Rockspring Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Murray — Middle: (NMI) — Last: Berger

4. DATE OF DEATH: Month: 10 — Day: 19 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-24-06

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Not Ascertainable

11. BIRTHPLACE (State or foreign country): New York City, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Berger

14. MOTHER'S MAIDEN NAME: Bertha Roman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 125-07-5923

INFORMANT: Hospital Records, VAH, Perry Point, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
083.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Encephalitis chronic with paralysis agitans (Parkinsonian syndrome)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-20 19 56, to 10-19- 19 59, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D. — ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-20-59

22c. NAME OF CEMETERY OR CREMATORY: Mt Carmel

22d. LOCATION (City, town, or county): Balto (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: JACK LEWIS, INC. — ADDRESS: 2100 Eutaw Place, Baltimore Md.

24a. REC'D BY REGISTRAR DATE: OCT 20 59

24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11289 — 11270 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21
d. STREET ADDRESS: Elkton, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lydia — Middle: D. — Last: Brennan
4. DATE OF DEATH: Month: Oct. — Day: 14 — Year: 1959

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 4, 1908
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elkton, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry O. Dean
14. MOTHER'S MAIDEN NAME: Martha Holt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
INFORMANT: Mr. Ralph H. Dean — Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Leukemia, Myelogenous — 204.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: about Feb-1959

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 19 59, to Oct 14 59, that I last saw the deceased alive on Oct 14 1959, and that death occurred at 2:30 p. M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Orland H. Speaker M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/17/59
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.
22d. LOCATION (City, town, or county) (State): nr. Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pippin Funeral Home — ADDRESS: Elkton,
24a. REC'D BY REGISTRAR DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Calhoun L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1-D, Film G250 10/22/59 iwk

11289

CERTIFICATE OF DEATH

Reg. Dist. No. 11271

1. PLACE OF DEATH
a. COUNTY Cecil (Cecilstle) — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Dennis Middle Last Burke

4. DATE OF DEATH Month Oct. Day 1 Year 1959

5. SEX Male
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 26, 1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Donald Burke
14. MOTHER'S MAIDEN NAME Essie Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
INFORMANT Essie Burke- Address Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERTONITIS — INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO (b) IMPERFORATE ANUS — FX 9/24/59 RT H
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 756.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/28/59 to Oct 1 1959 that I last saw the deceased alive on Oct 1 1959, and that death occurred at 3:30 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE Henry Davis M.D. ADDRESS (Street, city or town, state) Chesapeake City Md DATE SIGNED 10/2/59
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/4/59
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.
22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edw. R. Bell ADDRESS 909 Poplar St.
24a. REC'D BY REGISTRAR DATE OCT 5 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

2065278XV.5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11272

Reg. Dist. No. 11303

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Charlestown
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Lewis Last: Calvert
4. DATE OF DEATH: Month: 10 Day: 14 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-12-1902
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting Houses
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Robert Calvert~~ Robert Calvert
14. MOTHER'S MAIDEN NAME: Belle Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-07-9783
17. INFORMANT: Address: Mary Murphy, Charlestown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Partial decapitation of left side of head — INTERVAL BETWEEN ONSET AND DEATH:

976 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): with 12 gauge Single barrel Shot gun.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: 12-50 a. m. p. m. Month, Day, Year: 10 14 '59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Charlestown (County): Cecil (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): R.C. Dodson — 10-14-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-16-1959
22c. NAME OF CEMETERY OR CREMATORY: Charlestown Cemetery
22d. LOCATION (City, town, or county) (State): Charlestown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Pattison & Son — ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11290

CERTIFICATE OF DEATH

11273 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Nursing Home - 224 E Main

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall — 14 x 2
d. STREET ADDRESS: Gratitude Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: W. — Last: Coleman
4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 1959
5. SEX: M.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 9, 1871
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: fishing
11. BIRTHPLACE (State or foreign country): Kent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wm Coleman
14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-20-8908
17. INFORMANT: Address: Mr. Wesley Coleman - Rock Hall, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertrophied Prostate. — INTERVAL BETWEEN ONSET AND DEATH
610X
DUE TO
(b): & retention
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ~~Arteriosclerosis~~ Arteriosclerosis - general. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 16, 1959, to Oct 12, 1959, that I last saw the deceased alive on Oct. 11, 1959, and that death occurred at 8:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Orford H. Spence M.D. — ADDRESS (Street, city or town, state): 135 W. Main, Elkton, Md — DATE SIGNED: Oct 12
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 14/59
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.
22d. LOCATION (City, town, or county) (State): Rock Hall. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Marvin V. Williams - Chestertown Md.
24a. REC'D BY REGISTRAR DATE: OCT 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11291 — 11274 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 22 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital Elkton, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton, R.D.3
d. STREET ADDRESS: Pleasant Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Webb — Middle: D — Last: Cox
4. DATE OF DEATH: Month: 10 — Day: 22 — Year: 19 59

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-4-1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Ash Co. N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willian Cox
14. MOTHER'S MAIDEN NAME: Cora Kneades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-32-0167
17. INFORMANT: Fred H. Cox, Elkton, R.D.1 Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bullet wound right side of head above right — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): temple bone with loss of blood and
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): brain tissue

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 22pistol shot self
20c. TIME OF INJURY: Hour: 1.40 A.M. P.M. — Month, Day, Year: 10-22 59
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Elkton R.D.3 Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R C Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED
EXAMINER'S NAME (Type): R.C.Dodson — 10-24-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-26-59
22c. NAME OF CEMETERY OR CREMATORY: Union Cem.
22d. LOCATION (City, town, or county) (State): Union Cecil Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Dippin Funeral Home by M. Du — ADDRESS: Elkton Md.
24a. REC'D BY REGISTRAR DATE: OCT 27 '59
24b. REGISTRAR'S SIGNATURE: Orlow E Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible] or removal. File pages 1 and 2 with the registrar.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11304

CERTIFICATE OF DEATH

11275
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

c. LENGTH OF STAY IN 1b: Lifetime

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: J Middle: Edward Last: Davis

4. DATE OF DEATH: Month: October Day: 15 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 1, 1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist

10b. KIND OF BUSINESS OR INDUSTRY: Drug

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. Davis

14. MOTHER'S MAIDEN NAME: Catherine L. Lake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 327-03-9184

17. INFORMANT Address: Cornelia W. Pratt, North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Suddenly

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): cardio vascular disease — 4 years

DUE TO (c): arterio sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1954, 19____, to Oct. 15, 1959, that I last saw the deceased alive on Oct. 14, 1959 and that death occurred at 7A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. A. Cantwell M.D.

ADDRESS (Street, city or town, state): North East, Maryland

DATE SIGNED

PHYSICIAN'S NAME (Type): H.A.Cantwell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-17-1959

22c. NAME OF CEMETERY OR CREMATORY: North East, Methodist

22d. LOCATION (City, town, or county) (State): North East Cecil Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant

ADDRESS: Joseph R. Grant North East, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Clarkson L. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11305

11276

Reg. Dist. No. .....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within **24 hours** after death. The bottom portion may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun

LENGTH OF STAY (in this place) 10 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun

STREET ADDRESS (If rural give location) R.D.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) F. (Last) Edwards

4. DATE OF DEATH (Month) October (Day) 25, (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	August 18, 1867	92 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMING-	FARMER	North Carolina	U.S.A.

13. FATHER'S NAME Nathanial Edwards

14. MOTHER'S MAIDEN NAME Nancy Chapel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS Mrs. Elizabeth E. Sheridan RD#2, Box 86 Aberdeen, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 Days

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis — 4 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19 59, to Oct 25, 19 59, that I last saw the deceased alive on Oct 26, 19 59, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE I. Edmund Green M.D. ADDRESS (Street, city, town, state) Darlington Md. DATE SIGNED 10/26/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial Oct 28 '59	Oct 28, 1959	Mt. Zion Cemetery	Fountain Green, Rt 8 Bel Air, Harf. Co., Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE Oct 2 '59		Joseph W. Foster	W. Broadway + W. Hanna St. Bel Air, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11306

CERTIFICATE OF DEATH

11277

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1yr. 4mo. 23days
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital
d. STREET ADDRESS: 1314 T St.,S.E.,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle E. Last EMMETT
4. DATE OF DEATH: Month October Day 13, Year 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-25-94
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Nav.Gun Fac.
10b. KIND OF BUSINESS OR INDUSTRY: Federal
11. BIRTHPLACE (State or foreign country): Halifax,N.S.,Canada.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William J. Emmett
14. MOTHER'S MAIDEN NAME: Mary J. Babcock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO: 578-03-3480
INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I VA attended the deceased from May 20, 1958, to October 13, 1959, [illegible] and that death occurred at 7:45 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: B. Rothfeld M.D.
ADDRESS (Street, city or town, state): V.A. Hospital,Perry Point, Md.
DATE SIGNED: 10-14-59
PHYSICIAN'S NAME (Type): B. ROTHFELD
Asst. Chief, Medical Service

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 16-59
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Bladensburg Md
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Simmons Bros.Fun.Home,Good Hope Road S.E.Wash.D.C.
24a. REC'D BY REGISTRAR DATE: OCT 15 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Simmons Brothers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11292

11278

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton,

c. LENGTH OF STAY IN 1b: 2 Yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington 4 X 3

d. STREET ADDRESS: 6th & Lehigh Court Church St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Jane — Last: Farrow

4. DATE OF DEATH: Month: 10 — Day: 20 — Year: 19 59

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-14-1890

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible] U.S.

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 222-14-3[illegible]

INFORMANT — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute cerebrovascular accident (6) — INTERVAL BETWEEN ONSET AND DEATH: 69 days

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)

20c TIME OF INJURY Hour: o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 14, 1959 to Oct. 20, 19___, that I last saw the deceased alive on Oct. 20, 1959, and that death occurred at 7:15p M, from the causes and on the date stated above

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.

ADDRESS (Street city or town, state): 233 E. Main Sr.

DATE SIGNED: 10/20/59

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/24/59

22c. NAME OF CEMETERY OR CREMATORY: Silverbrook Cemetery

22d. LOCATION (City, town, or county) (State): Wilmington, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: N Wallin Andrews Jr. — ADDRESS: Elkton Md

24a. REC'D BY REGISTRAR DATE: OCT 23 '59

24b REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11293 **CERTIFICATE OF DEATH** 11279

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Curtis — Middle C. — Last Ford

4. DATE OF DEATH: Month 10 — Day 24 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-16-1885

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: Camp Chesapeake

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Ford

14. MOTHER'S MAIDEN NAME: Annie -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Malcolm C. Ford — Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min

DUE TO (b): Left lower lobe viral pneumonia — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 Oct 1959 to 24 Oct 1959 that I last saw the deceased alive on 23 Oct 1959, and that death occurred at 1 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East, Md — DATE SIGNED: 24 Oct '59

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-27-1959

22c. NAME OF CEMETERY OR CREMATORY: St. Mark's A.M.E. CEMP

22d. LOCATION (City, town, or county) (State): North East Cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11280

11307

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun Rural, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alfred — Middle: Hearns — Last: Gamble

4. DATE OF DEATH: Month: October — Day: 29 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1919

9 AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Signal Maintainer

10b. KIND OF BUSINESS OR INDUSTRY: Pa. Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Gamble

14 MOTHER'S MAIDEN NAME: Blanche Slicer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-14-8972

INFORMANT: Mrs. Helen J. Gamble, RFD, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO (b): hypertension — 2 yrs.

DUE TO (c):

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10/1, 1959 to 10/29, 1959, that I last saw the deceased alive on 10/29, 1959, and that death occurred at 5 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor Jr M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md. — DATE SIGNED: 10/29/59

PHYSICIAN'S NAME (Type): Neil Taylor Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/1/59

22c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery

22d. LOCATION (City, town, or county) (State): Port Deposit, Rfd, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Julia Patterson & Son — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: NOV 2 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Howard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11281

11308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

c. LENGTH OF STAY IN 1b: Lifetime

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cremella Middle: Last: Hammond

4. DATE OF DEATH: Month: 10 Day: 15 Year: 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 13, 1906

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel P. Jones

14. MOTHER'S MAIDEN NAME: Susie Warrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Paul C. Hammond Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Hypernephroma of left Kidney — INTERVAL BETWEEN ONSET AND DEATH: 21 months

DUE TO: —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: — —

(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): —

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year: — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town): — (County): — (State): —

21. I certify that I attended the deceased from 15 April, 1959, to 15 Oct, 1959, that I last saw the deceased alive on 5 Oct, 1959, and that death occurred at 8 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. ADDRESS (Street, city or town; state): North East, Md DATE SIGNED: 16 Oct '59

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-19-1959

22c. NAME OF CEMETERY OR CREMATORY: Trinity

22d LOCATION (City, town, or county) (State): Zion Rural Cecil Co., Md

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant Joseph R. Grant ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11309 **CERTIFICATE OF DEATH** Reg. Dist. No. 11282

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit, Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Eva Middle Mary Last Jackson

4. DATE OF DEATH: Month Oct. Day 27, Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4 / 25 / 1876
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Cecil Co. Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William McNamee
14. MOTHER'S MAIDEN NAME: Annie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Howard D. Jackson Jr. Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
450.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from Nov 19 56 to 27 Oct 19 59 that I last saw the deceased alive on 12 Oct 19 59, and that death occurred at 12:15 M. from the causes and on the date stated above.

ACTUAL SIGNATURE Klaus H. Huebner M.D. ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 10/27/59

PHYSICIAN'S NAME (Type) Klaus H. Huebner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/31/1959
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cem.
22d. LOCATION (City, town, or county) (State): Rising Sun, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen ADDRESS: Rising Sun Md.
24a. REC'D BY REGISTRAR DATE: OCT 30 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11283 Reg. Dist. No.

11310

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R. D. #4
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton R. D. #4
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First John Middle Last Krusberg
4. DATE OF DEATH: Month Oct. Day 29. Year 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 11, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter
11. BIRTHPLACE (State or foreign country): Estonia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Krusberg
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-01-1528
17. INFORMANT Address: Mrs. Bertha Krusberg, R. D. #4, Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
33/x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PR MARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: R. C. Dodson M.D. — CHIEF MEDICAL EXAMINER [ ] — DATE SIGNED
EXAMINER'S NAME (Type): R. C. Dodson — ASSISTANT MEDICAL EXAMINER [ ] — DEPUTY MEDICAL EXAMINER [X] — 10-30-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 31, 1959
22c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY
22d. LOCATION (City, town, or county) (State): ELKTON, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Sr.
ADDRESS: ELKTON, Md
24a. REC'D BY REGISTRAR DATE NOV 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records or to burial, cremation, or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11311

CERTIFICATE OF DEATH

11284
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point
c. LENGTH OF STAY IN 1b 4yrs3mos23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Penna. b. COUNTY Chester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennett Square 75X-3
d. STREET ADDRESS 312 Meredith St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last LEARY
4. DATE OF DEATH Month October Day 27 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH January 7,1878
9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10b KIND OF BUSINESS OR INDUSTRY Unknown
11 BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JEREMIAH LEARY
14. MOTHER'S MAIDEN NAME MARY ANN FOLEY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) SAM
16. SOCIAL SECURITY NO. Unknown
INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis due to arteriosclerosis. — INTERVAL BETWEEN ONSET AND DEATH: Unknown

3 > 2 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I VA attended the deceased from July 4, 1955, to October 27, 1959, [illegible] and that death occurred at 10:45 AM from the causes and on the date stated above.

ACTUAL SIGNATURE Richard H Sundermann M.D.
ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.
DATE SIGNED 10-27-59

PHYSICIAN'S NAME (Type) RICHARD H. SUNDERMANN, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
22b DATE THEREOF 10-30-59
22c. NAME OF CEMETERY OR CREMATORY St Patricks Cemetery
22d. LOCATION (City, town, or county) (State) Kennett Square, Pa. 10-30-59

23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant
ADDRESS North East, Md.
24a. REC'D BY REGISTRAR DATE OCT 29 '59
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11294 · **CERTIFICATE OF DEATH** Reg. Dist. No. 11285

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Agnes Last: Lewis

4. DATE OF DEATH: Month: Oct. Day: 7 Year: 1959

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 5, 1871

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Sanders

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT Address: Mrs. Clarence Rambo, Elkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio-vascular Renal —
4-42 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS A AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Oct 1, 1959, to Oct 7, 1959, that I last saw the deceased alive on Oct. 6, 1959, and that death occurred at 12:10 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Milford H. Sprecher M.D. ADDRESS (Street, city or town, state): Elkton, Md. DATE SIGNED: Oct 7-59

PHYSICIAN'S NAME (Type): Milford H. Sprecher, M.D., Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/9/59

22c. NAME OF CEMETERY OR CREMATORY: Charlestown Cemetery

22d. LOCATION (City, town, or county) (State): Charlestown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11312 **CERTIFICATE OF DEATH** Reg. Dist. No. 11286

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City

c. LENGTH OF STAY IN 1b: 3 Mons.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marian Nursing Home, Chesapeake City, Md.

d STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle V. Last Loveless

4. DATE OF DEATH: Month Oct. Day 23, Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27, 1879

9. AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Elkton, Md.

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas E. Meredith

14. MOTHER'S MAIDEN NAME: Elizabeth Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-30-5004

17. INFORMANT: Mrs. Elizabeth Houston

Address: New Castle, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive arteriosclerotic cardiovascular disease — unknown

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 31, 1959, to Oct. 23, 1959, that I last saw the deceased alive on Oct. 8 1959, and that death occurred at 5:20 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr., M.D. M.D.

ADDRESS (Street, city or town, state): 233 E. Main St. Elkton, Maryland

DATE SIGNED: 10/24/59

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 27, 1959

22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery

22d. LOCATION (City, town, or county) (State): Mt. Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pippin Funeral Home

ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: OCT 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG250 10-27-59 et

11313

CERTIFICATE OF DEATH

11287

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY
c. LENGTH OF STAY IN 1b: 39 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: M.D. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MARTHA — Middle — Last LUZETSKY
4. DATE OF DEATH: Month OCT. — Day 17 — Year 1959

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 22, 1890
9 AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): AUSTRIA
12. CITIZEN OF WHAT COUNTRY? AUSTRIA

13. FATHER'S NAME: PHILIP KANAK
14. MOTHER'S MAIDEN NAME: Justina (Last name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: NONE
INFORMANT: ALEXANDER LUZETSKY — Address: CHES.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 10, 1959, to Oct 17, 1959, that I last saw the deceased alive on Oct 17, 1959, and that death occurred at 2.00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry V. Davis M.D.
ADDRESS (Street, city or town, state): Chesapeake City, Md
DATE SIGNED: 10/18/59
PHYSICIAN'S NAME (Type): HENRY V. DAVIS M.D.

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL
22b DATE THEREOF: OCT. 20, 1959
22c NAME OF CEMETERY OR CREMATORY: ST. ROSES
22d LOCATION (City, town, or county) (State): CHESAPEAKE CITY, MD

23 FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME
ADDRESS: ELKTON MD.
24a REC'D BY REGISTRAR DATE: OCT 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. The ■ please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11314

CERTIFICATE OF DEATH

Reg. Dist. No. 11288

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural
c. LENGTH OF STAY IN 1b: Life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Woodlawn
d. STREET ADDRESS: Woodlawn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: B. Last: Marshall
4. DATE OF DEATH: Month: Oct. Day: 13 Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 23, 1905
9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Store
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert B. Marshall
14. MOTHER'S MAIDEN NAME: Annie L. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 218-32-2319
INFORMANT: Florence E. Marshall, Address: Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.0
DUE TO (b): Coronary Artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/4, 19 59, to 10/13, 19 59, that I last saw the deceased alive on 10/13/59, 19 59, and that death occurred at 3 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Irvin L. Wachsman M.D. ADDRESS (Street, city or town, state): 907 S. Union Ave DATE SIGNED: 10/13/59
PHYSICIAN'S NAME (Type): Irvin L. Wachsman, M.D. I have certified

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-18-1959.
22c. NAME OF CEMETERY OR CREMATORY: Hopewell Cem.
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of decease.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11315

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: Less than 24 hrs.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 W. 14
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital
d. STREET ADDRESS: 2502 Lakeland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle C. — Last MASER

4. DATE OF DEATH: Month October — Day 14 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-5-20

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Refrigeration

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Maser

14. MOTHER'S MAIDEN NAME: Elizabeth Siegrist

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 218 10 6230

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D.

EXAMINER'S NAME (Type): R. C. DODSON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-14-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-19-59

22c. NAME OF CEMETERY OR CREMATORY: Balto Nat Kennedy

22d. LOCATION (City, town, or county) (State): Frederick Rd Balto MD

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Foulson — ADDRESS: 2359 Wash Blvd Balto 30 Md

24a. REC'D BY REGISTRAR — DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Clinton L. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11375 — 11290 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hacks Point Earlville, R.D.1.
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earlville, R.D. Hacks Point
d. STREET ADDRESS: Hacks Point
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: W — Last: May
4. DATE OF DEATH: Month: 10 — Day: 13 — Year: 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-10-1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State Road Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph E. May
14. MOTHER'S MAIDEN NAME: Sadie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-12-1490
17. INFORMANT: Eugene May. Address: Earville. R.D.1.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Diabetes
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 10-13-59
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-16-59
22c. NAME OF CEMETERY OR CREMATORY: Johntown Cem
22d. LOCATION (City, town, or county) (State): Earleville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Elwood Faulkner — ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR DATE: OCT 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kenna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11317

CERTIFICATE OF DEATH

Reg. Dist. No. 11291

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 53 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cecil Ave.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryvill e
d STREET ADDRESS: Cecil Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Mary Middle Christina Last McCommons

4. DATE OF DEATH: Month Oct. Day 31 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan.18,1874
9 AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER S NAME: John Smith
14 MOTHER'S MAIDEN NAME: Pricilla Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: None
INFORMANT: Mrs William W. White, Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 19 months
DUE TO (b) Arterial Sclerosis — Slight
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. Myocarditis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 19 59 to Oct. 30 19 59 that I last saw the deceased alive on Oct. 30 19 59 and that death occurred at M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson M.D. — ADDRESS (Street, city or town, state): Port Deposit, Md. — DATE SIGNED: Nov. 1 1959

PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-3-1959
22c. NAME OF CEMETERY OR CREMATORY: Angel Hill
22d. LOCATION (City, town, or county) (State): Havre De Grace, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Lewis Patterson & Sons — ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: NOV 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11295 **CERTIFICATE OF DEATH** 11292

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKton
c. LENGTH OF STAY IN 1b
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City
d. STREET ADDRESS —
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Baby Middle Last Ott

4. DATE OF DEATH Month Oct. Day 26 Year 1959

5. SEX M
6. COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct. 25, 1959
9 AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours 3 Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter L. Ott
14. MOTHER'S MAIDEN NAME Charlotte COSNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
INFORMANT Address Walter L. Ott

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute respiratory failure — INTERVAL BETWEEN ONSET AND DEATH 10 min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coma in obstructed respiratory system 5 hours
DUE TO
(c) Prematurity " "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from Oct 25, 1959, to Oct 26, 1959, that I last saw the deceased alive on Oct 26, 1959, and that death occurred at 2:12 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Peter J. Ayres M.D ADDRESS (Street, city or town, state) 15 Main St Elkton Md DATE SIGNED 10-26-59
PHYSICIAN'S NAME (Type) PETER J AYRES Elkton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/27/59
22c NAME OF CEMETERY OR CREMATORY ELKton Cemetery
22d. LOCATION (City, town, or county) (State) ELKton Md.

23 FUNERAL DIRECTOR'S SIGNATURE H. Walter du Bois Jr. ADDRESS Elkton, Md.
24a. REC'D BY REGISTRAR DATE OCT 29 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

2-5191XVO

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11296

11294 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton — c. LENGTH OF STAY IN 1b: 4 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret Middle Shallcross Last Poe	4. DATE OF DEATH: Month October Day 8 Year 1959							
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Sept 3, 1867	9. AGE (In years last birthday): 92 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Hiram Whitaker Shallcross		14. MOTHER'S MAIDEN NAME: Elizabeth L. Quick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Margaret Dreydopple	Address: Elkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebal Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

331X

DUE TO (b): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED White at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: October 9, 1959

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10-11-1959	22c. NAME OF CEMETERY OR CREMATORY: North East Methodist	22d. LOCATION (City, town, or county) (State): North East, Cecil, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant	ADDRESS: North East, Maryland	24a. REC'D BY REGISTRAR DATE: OCT 13 '59	24b. REGISTRAR'S SIGNATURE: Arthur B. Kines	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11318

CERTIFICATE OF DEATH

11295

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, Md.
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: VAH., Perry Point

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 640 -W Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Arthur Middle N. Last Ray
4. DATE OF DEATH: Month October Day 19, Year 19 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/12/92
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert L. Ray
14. MOTHER'S MAIDEN NAME: Nanny (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: VAH., Perry Point, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia, Bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3/4 days
420.0
DUE TO (b): Arteriosclerotic Heart disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, Generalized, Severe
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that VA attended the deceased from October 5, 1959, to October 19, 1959, that I last saw the deceased [illegible] and that death occurred at 7:50a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D
ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md.
DATE SIGNED: 10-20-59
PHYSICIAN'S NAME (Type): J. L. GAREY, MD
Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/23/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 250 10-27-59 ams

11296

CERTIFICATE OF DEATH

11297

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Del
b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elsmere
d. STREET ADDRESS: 46 x
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle:; Last: Sachs

4. DATE OF DEATH: Month: 10; Day: 18; Year: 1959

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/18/59

9. AGE (In years last birthday): — yrs
IF UNDER 1 YEAR: Months: —; Days: —
IF UNDER 24 HRS: Hours: 2; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dr Kurt Sachs

14. MOTHER'S MAIDEN NAME: Ruth Feldanger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

INFORMANT: Dr Kurt Sachs (Address) Elsmere Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
776x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifton R. Brooks M D

ADDRESS (Street, city or town, state): Main Street, Newark, Delaware

DATE SIGNED:

PHYSICIAN'S NAME (Type): Clifton R. Brooks

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-19-1959

22c. NAME OF CEMETERY OR CREMATORY: Cathedral

22d. LOCATION (City, town, or county) (State): Wilmington Newcastle Del

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant, North East Md

ADDRESS:

24a. REC'D BY REGISTRAR DATE: OCT 22 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

2 - 3 2 x 10

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11319

CERTIFICATE OF DEATH

11297

Reg. Dist. No. 96

M

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3lyrs.1mo.26days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bouckville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

55

3. NAME OF DECEASED (Type or print): First FRED — Middle (NMI) — Last SCHAEFFER

4. DATE OF DEATH: Month October — Day 14 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-28-90

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): New York

12 CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

INFORMANT: Hospital Records, VAH, Perry Point, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis generalized severe - unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from August 18, 19 28, to October 14, 1959 [illegible] and that death occurred at 2:00p M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: J. L. Garey M.D. V.A. Hospital, Perry Point, Md

PHYSICIAN'S NAME (Type): J. L. GAREY Clinical Pathologist

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/20/59
22c NAME OF CEMETERY OR CREMATORY: Baltimore National
22d LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: OCT 26 '59

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11298 (Reg. Dist. No.) 11298

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Elton Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anthony — Middle J. — Last Schneider

4. DATE OF DEATH: Month 10 — Day 19 — Year 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/24/1891

9. AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Grocery store

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No record

14. MOTHER'S MAIDEN NAME: No record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.1

16. SOCIAL SECURITY NO.: 221-03-5844

17. INFORMANT: Mrs. May C. schneider — Address: Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cerebral arteriosclerosis — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Long-standing emphysema, severe hepato-renal failure with nephrosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 19 56, to 19 Oct, 19 59, that I last saw the deceased alive on 19 Oct 19 59, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Ohrenbuin M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 20 Oct 59

PHYSICIAN'S NAME (Type): Wallace Ohrenbuin — Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 22, 1959

22c. NAME OF CEMETERY OR CREMATORY: Johntown Cemetery

22d. LOCATION (City, town, or county) (State): Rural Earleville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: OCT 23 '59

24b. REGISTRAR'S SIGNATURE: Esther L. Kent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11299

CERTIFICATE OF DEATH

Reg. Dist. No. 11299

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton
d STREET ADDRESS: R.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna — Middle — Last Smith

DATE OF DEATH: Month October — Day 10, — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20, 1892
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Osolo
14. MOTHER'S MAIDEN NAME: Anna Osahla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edward J. Smith, Address: Elkton, Md. R.D.4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Heart congestion [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO
(c): A-H — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus Cystic kidney [illegible]

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 58, to 10-10, 19 59, that I last saw the deceased alive on 10-10, 19 59, and that death occurred at 9:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Elkton Md. — DATE SIGNED: 10-13-59

PHYSICIAN'S NAME (Type): Peter Stavrakis M.D. Elkton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/14/59
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: OCT 23 59
24b. REGISTRAR'S SIGNATURE: Carling L. Knull

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11300

CERTIFICATE OF DEATH

11300 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [redacted] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 37 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) — a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21
d. STREET ADDRESS: Elkton, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Francis — Middle: DuPont — Last: Thomson
4. DATE OF DEATH: Month: Oct — Day: 14 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: June 1, [redacted]1869
9. AGE (In years last birthday): 90 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Engineering
11. BIRTHPLACE (State or foreign country): Phila., Penna
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No Infor
14. MOTHER'S MAIDEN NAME: No Info

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
INFORMANT: Mrs. Sonya Burgher — Address: Rochester, N. Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-vascular-renal disease
442X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19__ to Oct. 14, 1959 that I last saw the deceased alive on Oct. 14, 1959, and that death occurred at 9:15 P. M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Durland H. Boucher M.D. ADDRESS (Street, city or town, state): Elkton, Md. DATE SIGNED: Oct 15, 1959
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/18/59
22c. NAME OF CEMETERY OR CREMATORY: Fredericksburg Cem.
22d. LOCATION (City, town, or county) (State): Fredericksburg, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Pi[illegible] Funeral Home ADDRESS: Donald M. Dee Elkton, Md.
24a. REC'D BY REGISTRAR DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Francis

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11320 — Reg. Dist. No. 11301

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
c. LENGTH OF STAY IN 1b: 4 Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Route # 40

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Elkton
d. STREET ADDRESS: U.S. Route # 40
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LEAH Middle TISHA Last TOMLINSON

4. DATE OF DEATH: Month October Day 1, Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 9, 1894
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Antique Dealer
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Wray
14. MOTHER'S MAIDEN NAME: Sarah Dudley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-20-5713
17. INFORMANT: Dr. Mary T. Perkins — Address: Columbia, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Accute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: ------
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: H. H. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/21-59
EXAMINER'S NAME (Type): H. C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Oct. 23, 1959
22c. NAME OF CEMETERY OR CREMATORY: Silverbrook Cremetory
22d. LOCATION (City, town, or county) (State): Wilmington, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] FUNERAL HOME
ADDRESS: Donald H. Lee Elkton, Md.
24a. REC'D BY REGISTRAR DATE: OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Esther S. Kness

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible] or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11321

CERTIFICATE OF DEATH

11302 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural North East
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Virginia Middle Elizabeth Last Travers

4. DATE OF DEATH: Month October Day 1 Year 1959

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-30-1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours 18 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George V. Travers
14. MOTHER'S MAIDEN NAME: Helen V. Veasey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -
17. INFORMANT: George V. Travers Address: North East Rd, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyaline Membrane Disease of Lungs — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
DUE TO
7730
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) —
DUE TO
(c) —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.): —
20c. TIME OF INJURY Hour a. m. p. m. Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f (City or town) — (County) — (State) —

21. I certify that I attended the deceased from 30 Sept, 1959, to 1 Oct, 1959, that I last saw the deceased alive on 1 Oct, 1959, and that death occurred at 5:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. M.D.
ADDRESS (Street, city or town, state): North East Md
DATE SIGNED: 10 Oct '59

PHYSICIAN'S NAME (Type): Klaus H. Huebner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: North East Methodist
22d LOCATION (City, town, or county) (State): North East, Cecil, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Peart
ADDRESS: North East, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 2 '59
24b REGISTRAR'S SIGNATURE: [illegible]

2065263XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11322 **CERTIFICATE OF DEATH** 11303

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY CECIL MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PERRYVILLE

c. LENGTH OF STAY IN 1b 2 YRS

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL-

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL PERRYVILLE

d. STREET ADDRESS 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ISABELLA Middle Last WHERRY

4. DATE OF DEATH Month October Day 21 Year 1959

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH AUGUST 27-1857

9. AGE (In years last birthday) 102 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE STOREY

14. MOTHER'S MAIDEN NAME ELIZABETH HICKMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Mrs L. B. ROBERTS, Address PERRYVILLE Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CHRONIC MYOCARDITIS	2 YRS
DUE TO (b)	CEREBRAL SCLEROSIS	1 YR
DUE TO (c)	ARTERIO-SCLEROSIS	8 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 . /

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 10, 1958 to Oct. 24, 1959, that I last saw the deceased alive on Oct. 24, 1959, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Clarence I. Benson M.D.

ADDRESS (Street, city or town, state) PORT DEPOSIT

DATE SIGNED

PHYSICIAN'S NAME (Type) CLARENCE I. BENSON Box 123 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10/25/59

22c. NAME OF CEMETERY OR CREMATORY New London Presbt.

22d. LOCATION (City, town, or county) New London. (State) Penna.

23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson

ADDRESS Rising Sun Md.

24a. REC'D BY REGISTRAR DATE OCT 26 '59

24b. REGISTRAR'S SIGNATURE C. Vernon S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11323 **CERTIFICATE OF DEATH** 11304

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham Pa. RD#2.
c. LENGTH OF STAY IN 1b: 47
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham Pa. RD#2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Bayard — Middle: Gaver — Last: Wilson

4. DATE OF DEATH: Month: Oct — Day: 16 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: August 9 1883

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cecil County Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Wilson

14. MOTHER'S MAIDEN NAME: Mary Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 182-32-1411

17. INFORMANT — Address: John W. Wilson Nottingham RD#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months.

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Adenocarcinoma of stomach — 1 year.

DUE TO (c): Chronic Gastritis & esophagitis. — 20 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1958, to Oct. 16, 1959, that I last saw the deceased alive on Oct 15, 1959, and that death occurred at 11:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John T. Brittingham M.D. ADDRESS (Street, city or town, state): 205 Locust St., Clifford, Penna. DATE SIGNED: 10-16-59

PHYSICIAN'S NAME (Type): John T. Brittingham

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 19, 1959

22c. NAME OF CEMETERY OR CREMATORY: Friends

22d. LOCATION (City, town, or county) (State): Calvert Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ralph M Reed, Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11301

CERTIFICATE OF DEATH

11305

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 39 yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital
d. STREET ADDRESS: 1 Elkton, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry; Middle: Seeds; Last: Young
4. DATE OF DEATH: Month: Oct. Day: 14, Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 26, 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate & Insurance
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilmington, Del.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Henry Young
14. MOTHER'S MAIDEN NAME: Emily Seeds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Nov. 1918
16. SOCIAL SECURITY NO.: 220-18-5726
INFORMANT: Mrs. Henry S. Young — Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
420.1
DUE TO
(b): Arteriosclerotic coronary artery disease — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 18, 1957, to Oct. 14, 1959, that I last saw the deceased alive on Oct. 14, 1959, and that death occurred at 7:50a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main St. — DATE SIGNED: 10/16/59

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR., M.D. — Elkton — Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/17/59
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cem.
22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pippin Funeral Home — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Krauk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB